

# SSI Managed Care

Division of Health Care Financing - Division of Disability & Elder Services  
Medicaid Services to the Disabled - February 23, 2005



# SSI Medicaid Managed Care

- Two counties are involved to date:
  - Milwaukee: enrollment begins April 2005
  - Dane: enrollment begins July 2005
- The Governor's 2005-2007 budget assumes additional counties will become involved and projects savings of:
  - SFY 2006: \$3.2 million AF (\$1.4 million GPR)
  - SFY 2007: \$9.7 million AF (\$4.0 million GPR)
- Monthly per-person savings are estimated to be 5% of the FFS costs: \$40 for Milwaukee County (cost is \$802) and \$33.50 for Dane County (cost is \$670).



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- Milwaukee County Implementation
  - Involve 26,000 adults
  - Four HMOs: Abri Health Plan, Managed Health Services, United HealthCare and iCare
- Dane County Implementation
  - Involves 5,300 adults
  - Is a partnership between Community Living Alliance, Dane County and the Dane County Mental Health Center.



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## Eligibility Requirements:

- Live in Milwaukee or Dane County
- Age 19 or older
- Receive Medicaid and SSI or SSI-related Medicaid because of a disability
- Not living in an institution or nursing home
- Not participating in a home or community-based waiver.

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- Voluntary Enrollment:
  - Dually-eligible persons (Medicaid and Medicare)
  - Persons in MAPP (Medicaid Purchase Plan)
- All In Opt Out Enrollment:
  - Applies to SSI and SSI-related eligibles who do not meet criteria for voluntary enrollment
  - Eligibles must remain in an HMO for 2 months.
  - Eligibles may return to FFS or change HMOs within the first 4 months or after 12 months of enrollment.



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## Contract Safeguards

- An in-depth evaluation of the provider network as a condition of certification
- The HMO must cover medications already in use by the enrollee until their prescriber orders a different drug.
- The HMO must authorize and cover services with the enrollee's current providers for the first 60 days of enrollment or until the first month following completion of the assessment and care plan.
- The HMO must honor FFS prior authorizations at the level approved for 60 days or under the first month following completion of the assessment and care plan.

